5.11 Identification of Direct and Indirect Costs Related to Medicaid Patient Care

(a) Costs related to Medicaid patient care as adjusted for price level depreciation as reported to the Division are classified as follows:

1. Direct patient costs:

   i. Routine service costs;
   ii. Ambulatory service cost; and
   iii. Ancillary service costs.

2. Mixed direct and indirect costs.

3. Indirect patient care:

   i. Institutional costs.

(b) Patient care general service and indirect costs (except as noted

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below) are then distributed to direct cost centers based on allocation statistics reported to the Division on the following basis:

Patient Care

General Service	Allocation Basis
CSS: Central Supply Services	Costed requisitions
DTY: Dietary	Patient Meals
HKP: Housekeeping	Hours of Services
L&L: Laundry and Linen	Pounds of Laundry
MRD: Medical Records	Percentage of Time Spent
PHM: Pharmacy	Cost of Drugs
EDR: Education and Research (not including Schools of Nursing and Allied Health)	Percentage of Time Spent
RSD: Residents	Accumulated Costs in Patient Care Cost Centers
PHY: Physicians Coverage (related to research and medical education)	Patient Days
A&G: Administration and General	Accumulated Cost
FIS: Fiscal	Accumulated Cost
PCC: Patient Care Coordination	Percentage of Time Spent
PLT: Plant (less capitalized interest and depreciation)	Square Feet
UTC: Utilities Cost	Square Feet

MAL: Malpractice Insurance	Accumulated Cost
OGS: Other General Services	Accumulated Cost

5.12 Patient care cost findings: direct costs per case, physician and non-physician

(a) Hospital case-mix shall be determined as follows:

1. Uniform Bill-Patient Summary (UB-PS) data are used for determination of hospital case-mix. The appropriate patient records for the reporting period corresponding with the Financial Elements Report are classified into Diagnosis Related Groups (DRGs) using the following items:

i. Principal diagnosis;
ii. Secondary diagnosis;
iii. Principal and other procedures;
iv. Age;
v. Sex;
vi. Discharge status; and
vii. Birthweight (newborn).

2. Outliers (patients displaying atypical characteristics relative to other patients, e.g., inordinately long or short lengths of stay) are determined by DRG using established trim points; any

case beyond a trim point is considered an outlier. Hospitals must make every attempt to correct unacceptable data and hospitals for which more than 10 percent of the UB-PS data are missing or unacceptable must resubmit data or correct the unusable data before case-mix estimation will be attempted (Refer to Section 7.2).

3. Outpatient case-mix will consist of emergency service, clinic, home health agency, renal dialysis, home dialysis, ambulatory surgery, same day psychiatry, and private referred patients, as reported to the Division.

4. Same Day Surgical Services are considered a clinical, outpatient service but are assigned to a DRG and reported on a UB-PS (a bill type 13X).

SUPERSEDES 93-11-MA(NJ)

APR 28 1999

TN 95-07

Supersedes TN 93-11 Effective Date MAR 6 1995

OFFICIAL

(b) Measures of resource use are listed as follows:

1. In order to calculate a DRG rate, it is necessary to allocate a hospital's cost to the services provided during the base period (refer to Appendix 1.6 for a numeric example). A Uniform Bill (UB) is generated for each patient discharged. Each UB contains a DRG, the days of service or charges, and the respective clinical information. This clinical information is the basis for the assignment of a DRG for the provided service.

2. For each patient with a UB, measures of resource use are calculated to distribute costs across the UBs. Measures of resource use represent services provided to patients associated with each cost center. The MRU for routine service cost is patient days, emergency room cost is emergency admissions, and for ancillary and therapeutic cost is ancillary and therapeutic service charge. The measures of resource use is adjusted by a ratio of admissions reported on the hospital's cost report divided by the total number of a hospital's UBs.

Center		Measure of Resource Use	Calculation of Inpatients
		ROUTINE SERVICES	
MSA &	Medical-Surgical Acute Care Units	Patient Days	Total LOS less ICU, CCU, NBN and OBS LOS ACU
PED & PSA & PSY &	Pediatrics Psychiatric Acute Care Units Psychiatric/ Psycho-logical Services		
OBS	Obstetrics		
BCU	Burn Care Unit		BCU LOS
ICU & CCU	Intensive Care Unit Coronary Care Unit	Patient Days	ICU + CCU LOS
NNI	Neo-Natal Intensive Care Care Unit	NNI Patient Days	Total ICU LOS for Newborn DRGs
NBN	Newborn Nursery	NBN Patient Days	Total LOS for Newborn DRGS less ICU LOS

	Center	Measure of Resource Use	Calculation of Inpatients
		ROUTINE SERVICES	
		AMBULATORY SERVICES	
EMR	Emergency Service	EMR Charges (Inpatient EMR Revenue EMR Admissions)	EMR Admissions
CLN	Clinics	CLN Charges	None
HHA	Home Health Agency	OHS Charges	None
		ANCILLARY SERVICES	
ANS	Anesthesiology	ANS Charges	Direct
CCA	Cardiac Catheterization	CCA Charges	Direct
DEL	Delivery and Labor Room	DEL Charges	Direct
DIA	Dialysis	DIA Charges	Direct
DRU	Drugs Sold to Patients	PHM Charges (DRU)	Direct
EKG	Electrocardiology & Diagnostic	EDG Charges	Direct
NEU	Neurology		
LAB	Laboratory	BBK Charges & LAB Charges	Direct
MSS	Medical Surgical Supplies Sold to Patients	CSS Charges (MSS)	Direct
NMD	Nuclear Medicine	NMD Charges	Direct
OCC	Occupational & Recreational	OPM Charges	Direct

Center		Measure of Resource Use	Calculation of Inpatients
	ROUTINE SERVICES		
SPA	Therapy & Speech Pathology and Audiology		
ORG ORR	Organ Acquisition & Operating and Recovery Rooms	ORR Charges	Direct
PHT	Physical Therapy	PHT Charges	Direct
RAD	Diagnostic Radiology	RAD Charges	Direct
RSP	Respiratory Therapy	RSP Charges	Direct
THR	Therapeutic Radiology	THR Charges	Direct

(c) Cost per case allocation:

1. The Direct Patient Care Costs of each center (after the allocation of patient care general services in section 5.11 and 5.12) are separated between inpatient, outpatient, and Skilled Nursing Facility (SNF) costs. Outpatient and SNF costs are excluded from the inpatient rates based on gross revenue reported to the Division. The total inpatient costs are then divided by the hospital's corresponding total adjusted measures of resource use. This calculation produces ratios, including cost-per-patient day, cost per EMR admission, or cost ratio per ancillary or therapeutic charge for each cost center. Each ratio is then multiplied by the corresponding cost center's measures of resource use of each DRG to calculate a cost per case for the hospital's case mix.

i. Patient days will be employed as the Measures of Resource Use to allocate MSA, PED, PSA, and OBS nursing costs. While patient days are used, the MSA, PED, PSA, OBS centers will be combined into ACU and ICU, and CCU will be combined into ICU. All other routine centers will remain as above.

5.13 Reasonable cost of services related to patient care

(a) The Reasonable Cost of Services related to Patient Care includes:

1. Current non-physician direct patient care costs per case as adjusted by standard costs per case for Medicaid inpatients;

2. Current physician patient service costs, as modified for physician compensation arrangements pursuant to section 5.12;

3. Indirect cost pursuant to sections 5.11 and 5.16;

4. Less a reduction for income not related to patient care, from those sources specified in sections 6.27 through 6.33 except all items reported as expense recovery to the Division, shall be so treated; and

5. Current major moveable equipment amount pursuant to Section 6.9.

(b) The reasonable Cost of Services Related to Medicaid Patient Care will be adjusted by the application of economic factors pursuant to Section 5.17

5.14 Standard costs per case

(a) The standard to be used in the calculation of proposed rates for each inpatient DRG is determined as the median non-physician patient care costs per Medicaid case in all hospitals whose costs are included in the data base and adjusted for labor market differentials. Standards shall be calculated across all hospitals for which current cost bases were derived from a common reporting period.

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